

FILED DEC 27 1950

STANDARD CERTIFICATE OF DEATH

1003

State File No.

42834

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 10537			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN City St Louis		c. LENGTH OF STAY (in this place) 8/17/48/12/50		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2139			
d. FULL NAME OF HOSPITAL OR INSTITUTION City Infirmary				13 STREET ADDRESS (If rural, give location) 5800 Arsenal St.					
3. NAME OF DECEASED (Type or Print) a. (First) William		b. (Middle) Shelton		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) 12 - 8 - 1950			
5. SEX Male		6. COLOR OR RACE Color.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower		8. DATE OF BIRTH Aug. 10, 1876			
9. AGE (In years last birthday) 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nil		11. BIRTHPLACE (State or foreign country) Mo.		12. CITIZEN OF WHAT COUNTRY?			
13a. FATHER'S NAME Nylon Shelton		13b. MOTHER'S MAIDEN NAME Judy ?		14. NAME OF HUSBAND OR WIFE Laviza ?					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS City Infirmary Records 5800 Arsenal St.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Lues				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4200					
22. I hereby certify that I attended the deceased from 8-17-48, 19, to 12-8-1950, that I last saw the deceased alive on 12-7-50, 19, and that death occurred at 4:20 p.m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Palmer August Borodish M.D.				23b. ADDRESS 5800 Arsenal St.		23c. DATE SIGNED 12-8-50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12/11/50		24c. NAME OF CEMETERY OR CREMATORY Oakdale Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis MO			
DATE REC'D BY LOCAL REG. DEC 11 1950		REGISTRAR'S SIGNATURE J B Lister		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Doyers Fun. Home, 622 E. 12th St. Kimbark, Mo.					

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.